108TH CONGRESS
1ST SESSION

S. 1332

To amend title XVIII of the Social Security Act to provide regulatory relief, appeals process reforms, contracting flexibility, and education improvements under the medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 25, 2003

Mr. HATCH introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act to provide regulatory relief, appeals process reforms, contracting flexibility, and education improvements under the medicare program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—REGULATORY REFORM

SEC. 101. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

''(d)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

''(i) such retroactive application is necessary to comply with statutory requirements; or

''(ii) failure to apply the change retroactively would be contrary to the public interest.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(d)(1), as added by subsection (a), is amended by adding at the end the following:

''(B) A compliance action may be made against a provider of services, physician, practitioner, or other supplier with respect to noncompliance with such a substantive change only for items and services furnished on or after the effective date of the change.

''(C)(i) Except as provided in clause (ii), a substantive change may not take effect until not earlier than the date that is the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

''(ii) The Secretary may provide for a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described

in the first sentence, and a brief statement of the reasons for such finding.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

SEC. 102. REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.

Section 1871 (42 U.S.C. 1395hh), as amended by section 101(a)(1), is amended by adding at the end the following new subsection:

''(e)(1) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

''(2) In preparing a report under paragraph (1), the Secretary shall collect—

''(A) information from beneficiaries, providers of services, physicians, practitioners, and other suppliers with respect to such areas of inconsistency and conflict; and

''(B) information from medicare contractors that tracks the nature of communications and cor-

respondence, including the communications and correspondence required under section 1874A.

''(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.''.

SEC. 103. STATUS OF PENDING INTERIM FINAL REGULATIONS.

Section 1871 (42 U.S.C. 1395hh) as amended by sections 101 and 102, is amended by adding at the end the following new subsection:

''(f) The Secretary shall publish in the Federal Register at lease once every 6 months a list that provides the status of each interim final regulation for which no final regulation has been published. Such list shall include the date by which the Secretary plans to publish the final regulation that is based on the interim final regulation.''.

TITLE II—APPEALS PROCESS REFORM

SEC. 201. SUBMISSION OF PLAN FOR TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) SUBMISSION OF TRANSITION PLAN.—

(1) IN GENERAL.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) CONTENTS.—The plan shall include information on the following:

(A) WORKLOAD.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) COST PROJECTIONS AND FINANCING.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan and how such transfer should be financed.

(C) TRANSITION TIMETABLE.—A timetable for the transition.

(D) REGULATIONS.—The establishment of specific regulations to govern the appeals process.

(E) CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) FEASIBILITY OF PRECEDENTIAL AUTHORITY.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

(G) ACCESS TO ADMINISTRATIVE LAW JUDGES.—The feasibility of—

(i) filing appeals with administrative law judges electronically; and

(ii) conducting hearings using tele- or video-conference technologies.

(H) INDEPENDENCE OF JUDGES.—The steps that should be taken to ensure that

judges who perform the administrative law judge functions after the transfer under the plan maintain their independence from the Centers for Medicare & Medicaid Services and its contractors.

(I) GEOGRAPHIC DISTRIBUTION.—The steps that should be taken to provide for an appropriate geographic distribution of judges performing the administrative law judge functions that are transferred under the plan throughout the United States to ensure timely access to such judges.

(J) HIRING.—The steps that should be taken to hire judges (and support staff) to perform the administrative law judge functions that are transferred under the plan.

(K) PERFORMANCE STANDARDS.—The establishment of performance standards for judges performing the administrative law judge functions that are transferred under the plan with respect to timelines for decisions in cases under title XVIII.

(L) SHARED RESOURCES.—The feasibility of the Secretary entering into such arrangements with the Commissioner of Social Security

as may be appropriate with respect to transferred functions under the plan to share office space, support staff, and other resources, with appropriate reimbursement.

(M) TRAINING.—The training that should be provided to judges performing the administrative law judge functions that are transferred under the plan with respect to laws and regulations under title XVIII.

(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (as amended by sections 521 and 522 of BIPA (114 Stat. 2763A–534) and this Act).

(b) GAO EVALUATION.—The Comptroller General of the United States shall—

(1) evaluate the plan submitted under subsection (a); and

(2) not later than 6 months after such submission, submit to Congress a report on such evaluation.

SEC. 202. EXPEDITED ACCESS TO JUDICIAL REVIEW.

(a) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)) is amended—

(1) in paragraph (1)(A), by inserting ", subject to paragraph (2)," before "to judicial review of the Secretary's final decision"; and

(2) by adding at the end the following new paragraph:

"(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

"(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or a beneficiary who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a

question of law or regulation for a specific matter in dispute in a case of an appeal.

''(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

''(C) ACCESS TO JUDICIAL REVIEW.—

''(i) IN GENERAL.—If the appropriate review entity—

"(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that the Departmental Appeals Board does not have authority to decide; or

"(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

"(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

"(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

"(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

"(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an

action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

''(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services,

physicians, practitioners, and other suppliers under this Act.

''(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, the term 'review entity' means an entity of up to 3 qualified reviewers drawn from existing appeals levels other than the redetermination level.''.

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting ''(A)'' after ''(h)(1)''; and

(2) by adding at the end the following new subparagraph:

''(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and beneficiaries may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.''.

(c) CONFORMING AMENDMENT.—Section 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is amended to read as follows:

"(ii) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For the provision relating to expedited access to judicial review, see paragraph (2).".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

SEC. 203. COST REPORT REFORM.

(a) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Secretary shall submit to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives a report recommending specific ways to modernize the cost reporting system under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such report shall be consistent with the recommendations of the Secretary's Advisory Committee on Regulatory Reform, including the use of Generally Accepted Accounting Principles.

(b) CONSULTATION.—In developing the report submitted under subsection (a), the Secretary shall consult

with representatives of the hospital industry, the Medicare Payment Advisory Commission, the General Accounting Office, and such other individuals and entities as the Secretary determines to be appropriate.

SEC. 204. EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.

(a) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—

(1) IN GENERAL.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which—

(A) the remedy of termination of participation has been imposed;

(B) a sanction described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) has been imposed, but only if such sanction has been imposed on an immediate basis; or

(C) the Secretary has required a skilled nursing facility to suspend operations of a nurse aide training program.

(2) PRIORITY FOR CASES OF TERMINATION.—Under the process described in paragraph (1), pri-

ority shall be provided in cases of termination described in subparagraph (A) of such paragraph.

(b) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums for fiscal year 2004 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges (and their staffs) at the Departmental Appeals Board of the Department of Health and Human Services and to educate such judges and staff on long-term care issues.

SEC. 205. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) TIMEFRAMES FOR THE COMPLETION OF THE RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 202(a)(2), is amended by adding at the end the following new paragraph:

''(3) TIMELY COMPLETION OF THE RECORD.—

''(A) DEADLINE.—Subject to subparagraph (B), the deadline to complete the record in a hearing before an administrative law judge

or a review by the Departmental Appeals Board is 90 days after the date the request for the review or hearing is filed.

''(B) EXTENSIONS FOR GOOD CAUSE.—The person filing a request under subparagraph (A) may request an extension of such deadline for good cause. The administrative law judge, in the case of a hearing, and the Departmental Appeals Board, in the case of a review, may extend such deadline based upon a finding of good cause to a date specified by the judge or Board, as the case may be.

''(C) DELAY IN DECISION DEADLINES UNTIL COMPLETION OF RECORD.—Notwithstanding any other provision of this section, the deadlines otherwise established under subsection (d) for the making of determinations in hearings or review under this section are 90 days after the date on which the record is complete.

''(D) COMPLETE RECORD DESCRIBED.—For purposes of this paragraph, a record is complete when the administrative law judge, in the case of a hearing, or the Departmental Ap-

peals Board, in the case of a review, has received—

"(i) written or testimonial evidence, or both, submitted by the person filing the request,

"(ii) written or oral argument, or both,

"(iii) the decision of, and the record for, the prior level of appeal, and

"(iv) such other evidence as such judge or Board, as the case may be, determines is required to make a determination on the request.".

(b) REVISIONS TO APPEALS TIMEFRAMES.—Section 1869 (42 U.S.C. 1395ff) is amended—

(1) in subsection (a)(3)(C)(ii), by striking "30-day period" each place it appears and inserting "60-day period";

(2) in subsection (c)(3)(C)(i), by striking "30-day period" and inserting "60-day period";

(3) in subsection (d)(1)(A), by striking "90-day period" and inserting "120-day period"; and

(4) in subsection (d)(2)(A), by striking "90-day period" and inserting "120-day period".

(c) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by inserting ''(including the medical records of the individual involved)'' after ''clinical experience''.

(d) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended by adding at the end the following new paragraph:

''(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall be provided in printed form and written in a manner to be understood by the beneficiary and shall include—

''(A) the reasons for the determination, including, as appropriate—

''(i) upon request in the case of an initial determination, the provision of the policy, manual, or regulation that resulted in the denial; and

"(ii) upon request, in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination (as appropriate);

"(B) the procedures for obtaining additional information concerning the determination or redetermination; and

"(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.".

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended to read as follows:

"(E) EXPLANATION OF DECISION.—Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing in a manner to be understood by the beneficiary and shall include—

"(i) to the extent appropriate, an explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision;

''(ii) a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section; and

''(iii) in the case of a determination of whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)) an explanation of the decision.''.

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)) is amended—

(A) in the heading, by inserting ''; NOTICE'' after ''SECRETARY''; and

(B) by adding at the end the following new paragraph:

''(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner to be understood by the beneficiary and shall include—

''(A) the specific reasons for the determination; and

''(B) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.''.

(4) PREPARATION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) is amended by striking ''such information as is required for an appeal'' and inserting ''the record for the appeal''.

(e) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c) (42 U.S.C. 1395ff(c)) is amended—

(A) in paragraph (2)—

(i) by inserting ''(except in the case of a utilization and quality control peer review organization, as defined in section 1152)'' after ''means an entity or organization that''; and

(ii) by striking the period at the end and inserting the following: ''and meets the following requirements:

''(A) GENERAL REQUIREMENTS.—

''(i) The entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing to carry out duties of a qualified

independent contractor under this section on a timely basis.

''(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

''(iii) The entity or organization meets such other requirements as the Secretary provides by regulation.

''(B) INDEPENDENCE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), an entity or organization meets the independence requirements of this subparagraph with respect to any case if the entity—

''(I) is not a related party (as defined in subsection (g)(5));

''(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

"(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

"(ii) EXCEPTION FOR COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

"(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional."; and

(B) in paragraph (3)(A), by striking ", and shall have sufficient training and expertise in medical science and legal matters to make reconsiderations under this subsection".

(2) ELIGIBILITY REQUIREMENTS OF REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) in subsection (c)(3)(B)(i), by striking ''a panel of physicians or other appropriate health care professionals'' and inserting ''a physician or another appropriate health care professional'';

(B) by striking subsection (c)(3)(D) and inserting the following:

''(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).''; and

(C) by adding at the end the following new subsection:

''(g) QUALIFICATIONS OF REVIEWERS.—

''(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall ensure that—

''(A) each individual conducting a review shall meet the qualifications of paragraph (2);

''(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

''(C) in the case of a review described in subsection (c)(3)(B) and conducted by a physician or another health care professional (each

in this subsection referred to as a 'reviewing professional'), that the reviewing professional meets the qualifications described in paragraph (4).

''(2) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

''(i) not be a related party (as defined in paragraph (5));

''(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

''(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of affiliation with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

''(I) a nonaffiliated individual is not reasonably available;

''(II) the affiliated individual is not involved in the provision of items or services in the case under review;

''(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized representative) and neither party objects; and

''(IV) the affiliated individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of such affiliation if the affiliation is disclosed to the Secretary and the beneficiary (or authorized representative), and neither party objects; or

''(iii) prohibit receipt of compensation by a reviewing professional from a con-

tractor if the compensation is provided consistent with paragraph (3).

''(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

''(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be a physician (allopathic or osteopathic) or health care professional who—

''(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

''(B) has medical expertise in the field of practice that is appropriate for the items or services at issue.

''(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving an individual beneficiary, any of the following:

''(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

''(B) The individual (or authorized representative).

''(C) The health care professional that provides the items or services involved in the case.

''(D) The institution at which the items or services (or treatment) involved in the case are provided.

''(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

''(F) Any other party determined under any regulations to have a substantial interest in the case involved.''.

(3) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking ''12'' and inserting ''4''.

(e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—

(1) DELAY IN CERTAIN BIPA REFORMS.—Section 521(d) of BIPA (114 Stat. 2763A–543) is amended to read as follows:

''(d) EFFECTIVE DATE.—

''(1) IN GENERAL.—Except as specified in paragraph (2), the amendments made by this section

shall apply with respect to initial determinations made on or after January 1, 2005.

''(2) EXPEDITED PROCEEDINGS AND RECONSIDERATION REQUIREMENTS.—The amendments made by subsection (a) shall apply with respect to initial determinations made on or after October 1, 2003 under the following provisions:

''(A) Subsection (b)(1)(F)(i) of section 1869 of the Social Security Act.

''(B) Subsection (c)(3)(C)(iii) of such section.

''(C) Subsection (c)(3)(C)(iv) of such section to the extent that it applies to expedited reconsiderations under subsection (c)(3)(C)(iii) of such section.

''(3) TRANSITIONAL USE OF PEER REVIEW ORGANIZATIONS TO CONDUCT EXPEDITED RECONSIDERATIONS UNTIL QICS ARE OPERATIONAL.—Expedited reconsiderations of initial determinations under section 1869(c)(3)(C)(iii) of the Social Security Act shall be made by peer review organizations until qualified independent contractors are available for such expedited reconsiderations.''.

(2) CONFORMING AMENDMENT.—Section 521(c) of BIPA (114 Stat. 2763A–543) and section

1869(c)(3)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1395ff(c)(3)(C)(iii)(III)), as added by section 521 of BIPA, are repealed.

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, 114 Stat. 2763A–534.

(g) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by subsection (d)(2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 206. HEARING RIGHTS RELATED TO DECISIONS BY THE SECRETARY TO DENY OR NOT RENEW A MEDICARE ENROLLMENT AGREEMENT; CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.

(a) HEARING RIGHTS.—

(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

''(j) HEARING RIGHTS IN CASES OF DENIAL OR NONRENEWAL.—The Secretary shall establish by regulation procedures under which—

''(1) there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment); and

''(2) a provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.''.

(2) EFFECTIVE DATE.—The Secretary shall provide for the establishment of the procedures under the amendment made by paragraph (1) within 18 months after the date of the enactment of this Act.

(b) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—Section 1871 (42 U.S.C. 1395hh), as amended by sections 101, 102, and 103, is amended by adding at the end the following new subsection:

''(g) The Secretary shall consult with providers of services, physicians, practitioners, and suppliers before

making changes in the provider enrollment forms required of such providers, physicians, practitioners, and suppliers to be eligible to submit claims for which payment may be made under this title.''.

SEC. 207. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

''(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services, physician, practitioner, or other supplier to appeal any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination and the provider of services, physician, practitioner, or other supplier would be prejudiced by the determination.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 208. PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.

(a) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—Section 1869(f)(5) (42 U.S.C. 1395ff(f)(5)) is amended to read as follows:

''(5) AGGRIEVED PARTY DEFINED.—In this section, with respect to a national or local coverage determination, the term 'aggrieved party' means—

''(A) an individual entitled to benefits under part A, or enrolled under part B, or both, who is in need of the items or services that are the subject of the coverage determination; or

''(B) a provider of services, physician, practitioner, or supplier that is adversely affected by such a determination.''.

(b) CLARIFICATION OF LOCAL COVERAGE DETERMINATION DEFINITION.—Section 1869(f)(2)(B) (42 U.S.C. 1395ff(f)(2)(B)) is amended by inserting '', including, where appropriate, a clear explanation of the reasons for the denial'' before the period at the end.

(c) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—Section 1869 (42 U.S.C. 1395ff), as amended by section 205(d)(2)(B), is amended by adding at the end the following new subsection:

''(h) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—

''(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a process under which a provider of services, physician, practitioner, or supplier who certifies that they meet the requirements established in paragraph (3) may request a local coverage determination in accordance with the succeeding provisions of this subsection.

''(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUEST DEFINED.—In this subsection, the term 'provider local coverage determination request' means a request, filed with the Secretary, at such time and in such form and manner as the Secretary may specify, that the Secretary, pursuant to paragraph (4)(A), require a fiscal intermediary, carrier, or program safeguard contractor to make or revise a local coverage determination under this section with respect to an item or service.

''(3) REQUEST REQUIREMENTS.—Under the process established under paragraph (1), by not later than 30 days after the date on which a provider local coverage determination request is filed under paragraph (1), the Secretary shall determine whether such request establishes that—

''(A) there have been at least 5 reversals of redeterminations made by a fiscal intermediary

or carrier after a hearing before an administrative law judge on claims submitted by the provider in at least 2 different cases before an administrative law judge;

''(B) each reversal described in subparagraph (A) involves substantially similar material facts;

''(C) each reversal described in subparagraph (A) involves the same medical necessity issue; and

''(D) at least 50 percent of the total number of claims submitted by such provider within the past year involving the substantially similar material facts described in subparagraph (B) and the same medical necessity issue described in subparagraph (C) have been denied and have been reversed by an administrative law judge.

''(4) APPROVAL OR REJECTION OF REQUEST.—

''(A) APPROVAL OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have been satisfied, the Secretary shall require the fiscal intermediary, carrier, or program safeguard contractor identified in the provider local coverage determination request, to make or revise a local

coverage determination with respect to the item or service that is the subject of the request not later than the date that is 210 days after the date on which the Secretary makes the determination. Such fiscal intermediary, carrier, or program safeguard contractor shall retain the discretion to determine whether or not, and/or the circumstances under which, to cover the item or service for which a local coverage determination is requested. Nothing in this subsection shall be construed to require a fiscal intermediary, carrier or program safeguard contractor to develop a local coverage determination that is inconsistent with any national coverage determination, or any coverage provision in this title or in regulation, manual, or interpretive guidance of the Secretary.

''(B) REJECTION OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have not been satisfied, the Secretary shall reject the provider local coverage determination request and shall notify the provider of services, physician, practitioner, or supplier that filed the request of the reason for such rejection and no further pro-

ceedings in relation to such request shall be conducted.''.

(d) STUDY AND REPORT ON THE USE OF CONTRACTORS TO MONITOR MEDICARE APPEALS.—

(1) STUDY.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study on the feasibility and advisability of requiring fiscal intermediaries and carriers to monitor and track—

(A) the subject matter and status of claims denied by the fiscal intermediary or carrier (as applicable) that are appealed under section 1869 of the Social Security Act (42 U.S.C. 1395ff), as added by section 522 of BIPA (114 Stat. 2763A–543) and amended by this Act; and

(B) any final determination made with respect to such claims.

(2) REPORT.—Not later than the date that is 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation and administrative action as the Commission determines appropriate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) EFFECTIVE DATES.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendments made by subsections (a) and (b) shall apply to—

(A) any review of any local coverage determination filed on or after January 1, 2004;

(B) any request to make such a determination made on or after such date; or

(C) any local coverage determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUESTS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests (as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c)) filed on or after the date of the enactment of this Act.

TITLE III—CONTRACTING REFORM

SEC. 301. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

''CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

''SEC. 1874A. (a) AUTHORITY.—

''(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

''(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

''(A) the entity has demonstrated capability to carry out such function;

''(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

''(C) the entity has sufficient assets to financially support the performance of such function; and

''(D) the entity meets such other requirements as the Secretary may impose.

''(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

''(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

''(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the 'appropriate' medicare adminis-

trative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services, physician, practitioner, facility, or supplier or class of provider of services, physician, practitioner, facility, or supplier.

''(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and beneficiary services functions as follows:

''(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, physicians, practitioners, facilities, suppliers, and individuals.

''(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

''(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Serving as a center for, and com-

municating to individuals entitled to benefits under part A or enrolled under part B, or both, with respect to education and outreach for those individuals, and assistance with specific issues, concerns, or problems of those individuals.

''(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services, physicians, practitioners, facilities, or suppliers.

''(E) COMMUNICATION WITH PROVIDERS.—Serving as a center for, and communicating to providers of services, physicians, practitioners, facilities, and suppliers, any information or instructions furnished to the medicare administrative contractor by the Secretary, and serving as a channel of communication from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

''(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions described in subsections (e) and (f), relating to

education, training, and technical assistance to providers of services, physicians, practitioners, facilities, and suppliers.

''(G) ADDITIONAL FUNCTIONS.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title.

''(5) RELATIONSHIP TO MIP CONTRACTS.—

''(A) NONDUPLICATION OF ACTIVITIES.—In entering into contracts under this section, the Secretary shall assure that activities of medicare administrative contractors do not duplicate activities carried out under contracts entered into under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

''(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

''(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

''(b) CONTRACTING REQUIREMENTS.—

''(1) USE OF COMPETITIVE PROCEDURES.—

''(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement, the Federal Acquisition Regulation, or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section.

''(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures, unless

laws with general applicability to Federal acquisition and procurement or the Federal Acquisition Regulation authorize the use of other procedures, under such a contract not less frequently than once every 8 years.

''(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors without regard to any provision of law requiring competition. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred and contact information for the contractors involved) to providers of services, physicians, practitioners, facilities, and suppliers affected by the transfer.

''(D) INCENTIVES FOR QUALITY.—The Secretary may provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

''(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the

Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Secretary finds pertinent.

''(3) PERFORMANCE REQUIREMENTS.—

''(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements. The Secretary shall make such performance requirements and measurement standards available to the public.

''(B) CONSIDERATIONS.—The Secretary shall include, as one of the standards, provider and beneficiary satisfaction levels.

''(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

''(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

''(ii) shall be used for evaluating contractor performance under the contract; and

''(iii) shall be consistent with the written statement of work provided under the contract.

''(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

''(A) to furnish to the Secretary such timely information and reports as the Secretary may

find necessary in performing his functions under this title; and

''(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

''(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

''(c) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor

for the making of payments by it under subsection (a)(4)(B).

''(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

''(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

''(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

''(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this sec-

tion if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

''(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such a payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

''(4) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the ''False Claims Act'').

''(5) INDEMNIFICATION BY SECRETARY.—

''(A) IN GENERAL.—Notwithstanding any other provision of law and subject to the succeeding provisions of this paragraph, in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of

such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from, or relating directly to, the claims administration process under this title, the Secretary may, to the extent specified in the contract with the contractor, indemnify the contractor (and such persons).

''(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the Secretary to be criminal in nature, fraudulent, or grossly negligent.

''(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

''(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a pro-

ceeding described in such subparagraph without the prior written approval of the Secretary to negotiate a settlement. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement are conditioned upon the Secretary's prior written approval of the final settlement.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

''(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.''.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act (as added by paragraph (1)) the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and sec-

tion 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows: ''PROVISIONS RELATING TO THE ADMINISTRATION OF PART A''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking ''agreement under this section'' and inserting ''contract under section 1874A that provides for making payments under this part''.

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking ''An agreement with an agency or organization under this section'' and inserting ''A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part''; and

(B) by striking ''such agency or organization'' and inserting ''such medicare administrative contractor'' each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART B''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking ''carriers'' and inserting ''medicare administrative contractors''; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking ''Each such contract shall provide that the carrier'' and inserting ''The Secretary'';

(ii) by striking ''will'' the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting ''shall'';

(iii) in subparagraph (B), in the matter before clause (i), by striking ''to the policyholders and subscribers of the carrier'' and inserting ''to the policyholders and subscribers of the medicare administrative contractor'';

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking ''if it makes determinations or payments with respect to physicians' services,''; and

(II) by striking ''carrier'' and inserting ''medicare administrative contractor'';

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking ''and shall contain'' and all that follows through the period; and

(ix) in the seventh sentence, by inserting ''medicare administrative contractor,'' after ''carrier,'';

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(F) in paragraph (7), by striking ''the carrier'' and inserting ''the Secretary'' each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B),'' and inserting ''contract under section 1874A that provides for making payments under this part'';

(C) in paragraph (3)(A), by striking ''subsection (a)(1)(B)'' and inserting ''section 1874A(a)(3)(B)'';

(D) in paragraph (4), by striking ''carrier'' and inserting ''medicare administrative contractor'';

(E) in paragraph (5), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier'' and ''carrier responses'' and inserting ''contract under section 1874A that provides for making payments under this part shall require the medicare administrative contractor'' and ''contractor responses'', respectively; and

(F) by striking paragraph (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking ''carrier or carriers'' and inserting ''medicare administrative contractor or contractors''.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking ''Each carrier having an agreement with the Secretary under subsection (a)'' and inserting ''The Secretary''; and

(ii) by striking ''Each such carrier'' and inserting ''The Secretary'';

(B) in paragraph (3)(A)—

(i) by striking ''a carrier having an agreement with the Secretary under subsection (a)'' and inserting ''medicare administrative contractor having a contract under section 1874A that provides for making payments under this part''; and

(ii) by striking ''such carrier'' and inserting ''such contractor'';

(C) in paragraph (3)(B)—

(i) by striking ''a carrier'' and inserting ''a medicare administrative contractor'' each place it appears; and

(ii) by striking ''the carrier'' and inserting ''the contractor'' each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking ''carriers'' and inserting ''medicare administrative contractors'' each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(B) in paragraph (2), by striking ''carrier'' and inserting ''medicare administrative contractor''.

(9) Subsection (p)(3)(A) is amended by striking ''carrier'' and inserting ''medicare administrative contractor''.

(10) Subsection (q)(1)(A) is amended by striking ''carrier''.

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to

take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this title, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO NEW AGREEMENTS AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to the date specified in paragraph (1)(A), the Secretary may, consistent with subparagraph (B), continue to

enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 during the time period without regard to any of the provider nomination provisions of such section.

(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP ACTIVITIES UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include agreements and contracts entered into pursuant to paragraph (2)(A).

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to an appropriate medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(g) REPORTS ON IMPLEMENTATION.—

(1) PROPOSAL FOR IMPLEMENTATION.—At least 1 year before the date specified in subsection (d)(1)(A), the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes a plan for an appropriate transition. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and

shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

TITLE IV—EDUCATION AND OUTREACH IMPROVEMENTS

SEC. 401. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following new section:

''PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

''SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (e), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services, physicians, practitioners, and suppliers.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—Section 1874A, as added by section 301(a)(1), is amended by adding at the end the following new subsection:

''(e) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—

''(1) METHODOLOGY TO MEASURE CONTRACTOR ERROR RATES.—In order to give medicare contractors (as defined in paragraph (3)) an incentive to implement effective education and outreach programs for providers of services, physicians, practitioners, and suppliers, the Secretary shall develop and implement by October 1, 2004, a methodology to measure the specific claims payment error rates

of such contractors in the processing or reviewing of medicare claims.

''(2) IG REVIEW OF METHODOLOGY.—The Inspector General of the Department of Health and Human Services shall review, and make recommendations to the Secretary, regarding the adequacy of such methodology.

''(3) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' includes a medicare administrative contractor, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.''.

(c) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) INCREASED FUNDING FOR ENHANCED EDUCATION AND TRAINING THROUGH MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4) (42 U.S.C. 1395i(k)(4)) is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)'';

(B) in subparagraph (B), by striking ''The amount appropriated'' and inserting ''Subject

to subparagraph (C), the amount appropriated''; and

(C) by adding at the end the following new subparagraph:

''(C) ENHANCED PROVIDER EDUCATION AND TRAINING.—

''(i) IN GENERAL.—In addition to the amount appropriated under subparagraph (B), the amount appropriated under subparagraph (A) for a fiscal year (beginning with fiscal year 2004) is increased by $35,000,000.

''(ii) USE.—The funds made available under this subparagraph shall be used only to increase the conduct by medicare contractors of education and training of providers of services, physicians, practitioners, and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses to written and phone inquiries from providers of services, physicians, practitioners, and suppliers.''.

(2) TAILORING EDUCATION AND TRAINING FOR SMALL PROVIDERS OR SUPPLIERS.—

(A) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsection:

''(b) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

''(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall take into consideration the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

''(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

''(A) an institutional provider of services with fewer than 25 full-time-equivalent employees; or

''(B) a physician, practitioner, or supplier with fewer than 10 full-time-equivalent employees.''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2004.

(d) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (c)(2), is amended by adding at the end the following new subsections:

''(c) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services, physicians, practitioners, or suppliers for the purpose of conducting any type of audit or prepayment review.

''(d) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor—

''(1) of the screens used for identifying claims that will be subject to medical review; or

''(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

''(e) DEFINITIONS.—For purposes of this section and section 1817(k)(4)(C), the term 'medicare contractor' includes the following:

''(1) A medicare administrative contractor with a contract under section 1874A, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.

''(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services, physician, practitioner, or supplier an entity that has no authority under this title or title XI with respect to such activities and such provider of services, physician, practitioner, or supplier.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 402. ACCESS TO AND PROMPT RESPONSES FROM MEDICARE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 301(a)(1) and as amended by section 401(b)(1), is amended by adding at the end the following new subsection:

''(f) COMMUNICATING WITH BENEFICIARIES AND PROVIDERS.—

''(1) COMMUNICATION PROCESS.—The Secretary shall develop a process for medicare contractors to communicate with beneficiaries and with providers of services, physicians, practitioners, and suppliers under this title.

''(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare contractor (as defined in paragraph (5)) shall provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries by beneficiaries, providers of services, physicians, practitioners, and suppliers concerning the programs under this title within a contractual timeframe established by the Secretary.

''(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that medicare contractors provide a toll-free telephone number at which beneficiaries, providers, physicians, practitioners, and

suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

''(4) MONITORING OF CONTRACTOR RESPONSES.—

''(A) IN GENERAL.—Each medicare contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

''(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

''(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

''(B) DEVELOPMENT OF STANDARDS.—

''(i) IN GENERAL.—The Secretary shall establish (and publish in the Federal Register) standards regarding the accuracy, consistency, and timeliness of the information provided in response to inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

"(ii) EVALUATION.—In conducting evaluations of individual medicare contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

"(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

"(5) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in subsection (e)(3).".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect October 1, 2004.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out section 1874A(f) of the Social Security Act, as added by subsection (a).

SEC. 403. RELIANCE ON GUIDANCE.

(a) IN GENERAL.—Section 1871(d), as added by section 101, is amended by adding at the end the following new paragraph:

''(2) If—

''(A) a provider of services, physician, practitioner, or other supplier follows written guidance provided—

''(i) by the Secretary; or

''(ii) by a medicare contractor (as defined in section 1889(e) and whether in the form of a written response to a written inquiry under section 1874A(f)(1) or otherwise) acting within the scope of the contractor's contract authority, in response to a written inquiry with respect to the furnishing of items or services or the submission of a claim for benefits for such items or services;

''(B) the Secretary determines that—

''(i) the provider of services, physician, practitioner, or supplier has accurately presented the circumstances relating to such items,

services, and claim to the Secretary or the contractor in the written guidance; and

''(ii) there is no indication of fraud or abuse committed by the provider of services, physician, practitioner, or supplier against the program under this title; and

''(C) the guidance was in error;

the provider of services, physician, practitioner, or supplier shall not be subject to any penalty or interest under this title (or the provisions of title XI insofar as they relate to this title) relating to the provision of such items or service or such claim if the provider of services, physician, practitioner, or supplier reasonably relied on such guidance. In applying this paragraph with respect to guidance in the form of general responses to frequently asked questions, the Secretary retains authority to determine the extent to which such general responses apply to the particular circumstances of individual claims.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to penalties imposed on or after the date of the enactment of this Act.

SEC. 404. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: ''; MEDICARE PROVIDER OMBUDSMAN'';

(2) by inserting ''PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)'' after ''(a)'';

(3) in paragraph (1), as so redesignated under paragraph (2), by striking ''in this section'' and inserting ''in this subsection'';

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

''(b) MEDICARE PROVIDER OMBUDSMAN.—By not later than 1 year after the date of the enactment of the Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003, the Secretary shall appoint a Medicare Provider Ombudsman who shall have experience in health care. The Ombudsman shall—

''(1) provide assistance, on a confidential basis, to providers of services and suppliers with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or

conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

''(2) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

''(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration);

''(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers; and

''(C) recommendations to improve communication between providers, contractors, and the Centers for Medicare & Medicaid Services.

''(c) STAFF.—The Secretary shall provide appropriate staff to assist in performing the duties described in subsection (b).''.

(b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII is amended by inserting after section 1806 the following new section:

''MEDICARE BENEFICIARY OMBUDSMAN

''SEC. 1807. (a) IN GENERAL.—By not later than 1 year after the date of the enactment of the Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003, the Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman (including support staff) who shall have expertise and experience in the fields of health care and advocacy.

''(b) DUTIES.—The Medicare Beneficiary Ombudsman shall—

''(1) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

''(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

''(A) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary; and

''(B) assistance to such beneficiaries with any problems arising from disenrollment from a Medicare+Choice plan under part C; and

''(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.''.

(c) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5) and section 1807 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

(d) USE OF CENTRAL, TOLL-FREE NUMBER (1–800–MEDICARE).—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: ''By not later than 1 year after the date of the enactment of the Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003, the Secretary shall provide,

through the toll-free number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.''.

SEC. 405. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to medicare beneficiaries at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by medicare beneficiaries.

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 3 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) DURATION.—The demonstration program shall be conducted over a 3-year period.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local social security offices.

(2) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local social security offices.

TITLE V—REVIEW, RECOVERY, AND ENFORCEMENT REFORM

SEC. 501. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 301(a)(1) and as amended by sections 401(b)(1) and 402(a), is amended by adding at the end the following new subsection:

''(g) CONDUCT OF PREPAYMENT REVIEW.—

''(1) STANDARDIZATION OF RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor shall conduct random prepayment review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

''(2) LIMITATIONS ON INITIATION OF NONRANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate nonrandom prepayment review of a provider of services, physician, practitioner, or supplier based on the initial identification by that provider of services, physician, practitioner, or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

''(3) TERMINATION OF NONRANDOM PREPAYMENT REVIEW.—The Secretary shall establish protocols or standards relating to the termination, includ-

ing termination dates, of nonrandom prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review. In the case of a provider of services, physician, practitioner, or supplier with respect to which amounts were previously overpaid, nothing in this subsection shall be construed as limiting the ability of a medicare administrative contractor to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

''(5) RANDOM PREPAYMENT REVIEW DEFINED.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a)

shall take effect on the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(g) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(g)(1) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify. The Secretary shall develop and publish the standard protocol under such section by not later than 1 year after the date of the enactment of this Act.

SEC. 502. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1874A, as added by section 301(a)(1) and as amended by sections 401(b)(1), 402(a), and 501(a), is amended by adding at the end the following new subsection:

''(h) RECOVERY OF OVERPAYMENTS.—

''(1) USE OF REPAYMENT PLANS.—

"(A) IN GENERAL.—If the repayment, within the period otherwise permitted by a provider of services, physician, practitioner, or other supplier, of an overpayment under this title meets the standards developed under subparagraph (B), subject to subparagraph (C), and the provider, physician, practitioner, or supplier requests the Secretary to enter into a repayment plan with respect to such overpayment, the Secretary shall enter into a plan with the provider, physician, practitioner, or supplier for the offset or repayment (at the election of the provider, physician, practitioner, or supplier) of such overpayment over a period of at least 1 year, but not longer than 3 years. Interest shall accrue on the balance through the period of repayment. The repayment plan shall meet terms and conditions determined to be appropriate by the Secretary.

"(B) DEVELOPMENT OF STANDARDS.—The Secretary shall develop standards for the recovery of overpayments. Such standards shall—

"(i) include a requirement that the Secretary take into account (and weigh in

favor of the use of a repayment plan) the reliance (as described in section 1871(d)(2)) by a provider of services, physician, practitioner, and supplier on guidance when determining whether a repayment plan should be offered; and

''(ii) provide for consideration of the financial hardship imposed on a provider of services, physician, practitioner, or supplier in considering such a repayment plan.

In developing standards with regard to financial hardship with respect to a provider of services, physician, practitioner, or supplier, the Secretary shall take into account the amount of the proposed recovery as a proportion of payments made to that provider, physician, practitioner, or supplier.

''(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

''(i) the Secretary has reason to suspect that the provider of services, physician, practitioner, or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

''(ii) there is an indication of fraud or abuse committed against the program.

''(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services, physician, practitioner, or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

''(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

''(2) LIMITATION ON RECOUPMENT.—

''(A) NO RECOUPMENT UNTIL RECONSIDERATION EXERCISED.—In the case of a provider of services, physician, practitioner, or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration of such determination by a qualified independent contractor under section 1869(c), the Secretary may not take any action (or authorize any other person, including any

medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

''(B) PAYMENT OF INTEREST.—

''(i) RETURN OF RECOUPED AMOUNT WITH INTEREST IN CASE OF REVERSAL.—Insofar as such determination on appeal against the provider of services, physician, practitioner, or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest for the period in which the amount was recouped.

''(ii) INTEREST IN CASE OF AFFIRMATION.—Insofar as the determination on such appeal is against the provider of services, physician, practitioner, or supplier, interest on the overpayment shall accrue on

and after the date of the original notice of overpayment.

''(iii) RATE OF INTEREST.—The rate of interest under this subparagraph shall be the rate otherwise applicable under this title in the case of overpayments.

''(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(e).

''(3) PAYMENT AUDITS.—

''(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services, physician, practitioner, or supplier under this title, the contractor shall provide the provider of services, physician, practitioner, or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

''(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services, physician, practitioner, or supplier under this title, the contractor shall—

''(i) give the provider of services, physician, practitioner, or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appropriate corrective action plan;

''(ii) inform the provider of services, physician, practitioner, or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary); and

''(iii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

''(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

''(4) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consulta-

tion with organizations representing the classes of providers of services, physicians, practitioners, and suppliers, a process under which the Secretary provides for notice to classes of providers of services, physicians, practitioners, and suppliers served by a medicare contractor in cases in which the contractor has identified that particular billing codes may be over utilized by that class of providers of services, physicians, practitioners, or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

''(5) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare administrative contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

''(6) CONSENT SETTLEMENT REFORMS.—

''(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

''(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider

of services, physician, practitioner, or supplier a consent settlement, the Secretary shall—

"(i) communicate to the provider of services, physician, practitioner, or supplier in a nonthreatening manner that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment; and

"(ii) provide for a 45-day period during which the provider of services, physician, practitioner, or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

"(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services, physician, practitioner, or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

"(i) shall provide notice of such determination to the provider of services, physi-

cian, practitioner, or supplier, including an explanation of the reason for such determination; and

''(ii) in order to resolve the overpayment, may offer the provider of services, physician, practitioner, or supplier—

''(I) the opportunity for a statistically valid random sample; or

''(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

''(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services, physician, practitioner, or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services, physician, practitioner, or supplier agrees not to appeal the claims involved.''.

(b) EFFECTIVE DATES AND DEADLINES.—

(1) Not later than 1 year after the date of the enactment of this Act, the Secretary shall first—

(A) develop standards for the recovery of overpayments under section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a);

(B) establish the process for notice of over-utilization of billing codes under section 1874A(h)(4) of the Social Security Act, as added by subsection (a); and

(C) establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1874A(h)(5) of the Social Security Act, as added by subsection (a).

(2) Section 1874A(h)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date that is 1 year after the date of the enactment of this Act.

(3) Section 1874A(h)(3) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

(4) Section 1874A(h)(6) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

SEC. 503. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

(a) IN GENERAL.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(e) of the Social Security Act, as added by section 401(d)(1)) and representatives of providers of services, physicians, practitioners, facilities, and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services, physician, practitioner, facility, or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) DEADLINE.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 504. AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: ''Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than 5 years, except that, upon the request of an administrator of a Federal health care pro-

gram (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries of that program, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.

SEC. 505. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

''(f) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless—

''(1) there is a sustained or high level of payment error (as defined by the Secretary by regulation); or

''(2) documented educational intervention has failed to correct the payment error (as determined by the Secretary).''.

(b) EFFECTIVE DATE.—Section 1893(f) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

TITLE VI—OTHER IMPROVEMENTS

SEC. 601. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY AND HOSPITAL BENEFITS.

(a) IN GENERAL.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services and inpatient hospital services under part A of title XVIII of the Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 602. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) AVAILABILITY OF DATA.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to

identify skilled nursing facilities that are participating in the medicare program.

(b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL DISCHARGE PLANS.—

(1) IN GENERAL.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended—

(A) by striking ''hospice services'' and inserting ''hospice care and post-hospital extended care services''; and

(B) by inserting before the period at the end the following: ''and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a).

SEC. 603. EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES CONSIDERATION.

The Secretary shall ensure, before making changes in documentation guidelines for, or clinical examples of, or codes to report evaluation and management physician services under title XVIII of Social Security Act, that the process used in developing such guidelines, examples, or codes was widely consultative among physicians, reflects a broad consensus among specialties, and would allow verification of reported and furnished services.

SEC. 604. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Section 1868 (42 U.S.C. 1395ee), as amended by section 301(a), is amended by adding at the end the following new subsection:

''(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

''(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

''(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Tech-

nology and Innovation (appointed or designated under paragraph (4)).

''(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

''(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.''.

(b) METHODS FOR DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

''(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as 'new tests').

''(B) Determinations under subparagraph (A) shall be made only after the Secretary—

''(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

''(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

''(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and rec-

ommendations (and data on which the recommendations are based);

''(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

''(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

''(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

''(i) set forth the criteria for making determinations under subparagraph (A); and

''(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

''(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

''(E) For purposes of this paragraph:

''(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

''(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).''.

(c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA COLLECTION FOR USE IN THE MEDICARE INPATIENT PAYMENT SYSTEM.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter

time frame by the Centers for Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using of quarterly samples or special surveys or any other methods. The study shall include an analysis of whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

(2) REPORT.—By not later than October 1, 2004, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

SEC. 605. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) IN GENERAL.—The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) REFERENCE LABORATORY SERVICES DESCRIBED.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

SEC. 606. EMTALA IMPROVEMENTS.

(a) PAYMENT FOR EMTALA-MANDATED SCREENING AND STABILIZATION SERVICES.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

''(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such

an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2004.

(b) NOTIFICATION OF PROVIDERS WHEN EMTALA INVESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42 U.S.C. 1395dd(d)) is amended by adding at the end the following new paragraph:

''(4) NOTICE UPON CLOSING AN INVESTIGATION.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.''.

(c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN EMTALA CASES INVOLVING TERMINATION OF PARTICIPATION.—

(1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—

(A) in the first sentence, by inserting ''or in terminating a hospital's participation under this title'' after ''in imposing sanctions under paragraph (1)''; and

(B) by adding at the end the following new sentences: ''Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

SEC. 607. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP.

(a) ESTABLISHMENT.—The Secretary shall establish a Technical Advisory Group (in this section referred to

as the ''Advisory Group'') to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term ''EMTALA'' refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

(1) shall review EMTALA regulations;

(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) ADMINISTRATIVE MATTERS.—

(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chair-

person of the Advisory Group for the life of the Advisory Group.

(2) MEETINGS.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 608. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

''(D) In extraordinary, exigent, or other nonroutine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provi-

sion by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

''(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services provided by or under the supervision of a registered professional nurse and are provided nonroutinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.''.

(b) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(4) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 609. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking ''and'' at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting ''; and''; and

(3) by inserting after paragraph (4) the following new paragraph:

''(5) for individuals who are terminally ill and who have not made an election under subsection (d)(1), services that are furnished by a physician who is either the medical director or an employee of a hospice program and that consist of—

''(A) an evaluation of the individual's need for pain and symptom management, including the need for hospice care;

''(B) counseling the individual with respect to end-of-life issues, the benefits of hospice care, and care options; and

''(C) if appropriate, advising the individual regarding advanced care planning.''.

(b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under part A shall be the amount determined under a fee schedule established by the Secretary.''.

(c) CONFORMING AMENDMENT.—Section 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended by inserting before the comma at the end the following: ''and services described in section 1812(a)(5)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2004.

SEC. 610. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (R), by striking ''and'' at the end;

(B) in subparagraph (S), by striking the period at the end and inserting '', and''; and

(C) by inserting after subparagraph (S) the following new subparagraph:

''(T) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 or a State occupational safety and health plan that is approved under section 18(b) of such Act, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated).''; and

(2) by adding at the end of subsection (b) the following new paragraph:

''(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(T) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

''(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(T) by a hospital that is subject to the provisions of such Act.

''(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.''.

(b) EFFECTIVE DATE.—The amendments made by this subsection (a) shall apply to hospitals as of July 1, 2004.

SEC. 611. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) TECHNICAL AMENDMENTS RELATING TO ADVISORY COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking ''established under section 1114(f)''; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking ''under subsection (f)''; and

(ii) by striking ''section 1862(a)(1)'' and inserting ''subsection (a)(1)''.

(b) TERMINOLOGY CORRECTIONS.—(1) Section 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by section 521 of BIPA, is amended—

(A) in subclause (III), by striking ''policy'' and inserting ''determination''; and

(B) in subclause (IV), by striking ''medical review policies'' and inserting ''coverage determinations''.

(2) Section 1852(a)(2)(C) (42 U.S.C. 1395w–22(a)(2)(C)) is amended by striking ''policy'' and ''POLICY'' and inserting ''determination'' each place it appears and ''DETERMINATION'', respectively.

(c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is amended—

(1) in subparagraph (A)(iv), by striking ''subclause (I), (II), or (III)'' and inserting ''clause (i), (ii), or (iii)'';

(2) in subparagraph (B), by striking ''clause (i)(IV)'' and ''clause (i)(III)'' and inserting ''subparagraph (A)(iv)'' and ''subparagraph (A)(iii)'', respectively; and

(3) in subparagraph (C), by striking ''clause (i)'', ''subclause (IV)'' and ''subparagraph (A)'' and inserting ''subparagraph (A)'', ''clause (iv)'' and

''paragraph (1)(A)'', respectively each place it appears.

(d) OTHER CORRECTIONS.—Effective as if included in the enactment of section 521(c) of BIPA, section 1154(e) (42 U.S.C. 1320c–3(e)) is amended by striking paragraph (5).

(e) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall be effective as if included in the enactment of BIPA.

SEC. 612. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by adding after subsection (g) the following new subsection:

''(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

''(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental serv-

ices expressly covered under this title pursuant to actions taken by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.

SEC. 613. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) IN GENERAL.—Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended to read as follows: ''(ii) where the service was provided under a contractual arrangement between such physician or other person and a qualified entity (as defined by the Secretary) or other person, to the entity or other person if under such arrangement such entity or individual submits the bill for such service and such arrangement (I) includes joint and several liability for overpayment by such physician or other person and such entity or other person, and (II) meets such other program integrity and other safeguards as the Secretary may determine to be appropriate,''.

(b) CONFORMING AMENDMENTS.—

(1) The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking ''except to an employer or facility as described in clause (A)'' and inserting ''except to an employer, entity, or other person as described in subparagraph (A)''.

(2) Section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by adding at the end the following new sentence: ''Nothing in subparagraph (A)(ii) shall be construed to prohibit requirements for joint and several liability for contractual arrangements where such requirements are not explicitly stated in a statute.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made on or after 1 year after the date of the enactment of this Act.

SEC. 614. GAO STUDY AND REPORT REGARDING ILLINOIS COUNCIL DECISION.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the access of health care providers and beneficiaries under the medicare program under title XVIII of the Social Security Act to judicial review of the actions of the Secretary of Health and Human Services and the effects of the decision of the Supreme Court of the United States in Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1 (1999) on such access.

(b) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) to-

gether with recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

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